

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 012506	(X3) Date Survey Completed 04/13/2023
Name of Provider or Supplier Dothan Dialysis	Street Address, City, State 216 Graceland Drive, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0550	<p>POC-VASCULAR ACCESS-MONITOR/REFERRALS CFR(s): 494.90(a)(5)</p> <p>The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.</p> <p>This STANDARD is not met as evidenced by: Based on the review of the facility policy, medical records, observations and interview, it was determined the facility failed to ensure the staff followed their own procedure for utilization of the vascular access clamps. This affected 1 of 3 patients observed using a vascular access clamp, which was Patient Identifier (PI) # 10 and had the potential to affect all patient served by this facility. Findings include: Facility Procedure: Utilizing Vascular Access Clamps Procedure #: 1-04-08A Revision Date: April 2023 Procedure: 5. After placement of clamp, check for thrill and bruit above and below clamp. If thrill cannot be palpated or bruit heard, release clamp slightly and recheck until thrill can be palpated or bruit heard. Rationale: 5. If thrill is not palpate or bruit heard, blood flow in the access is diminished and clotting may occur. Procedure: ...8. Clamp may remain in place for 5-10 minutes before checking to see if bleeding has stopped. 9. Bruit and thrill must be re-checked a minimum of every 10 minutes while using access clamps... 1. An observation was conducted on 4/11/23 at 12:05 PM at station 18 with Employee Identifier (EI) # 9, Patient Care Technician (PCT), to observe the discontinuation of dialysis and post dialysis AVF/AVG access care for PI # 10. During an observation, EI # 9 applied a vascular access clamp to the venous access site while the patient held the arterial access site at 12:08 PM. EI # 9 failed to check for thrill and bruit above and below clamp after the placement of the clamp. EI # 9 did not return to the patient chair side until 12:22 PM, which was 14</p>

minutes later. EI # 2 did not check to see if bleeding had stopped and the bruit and thrill were present after 10 minutes per policy. An interview was conducted on 4/13/23 at 11:04 AM with EI # 1, Facility Administrator, who confirmed EI # 9 did not follow the policy for vascular access clamps.